

# **Medical Assistance Administration**



## **Licensed Health Carriers**

**Instructions for Billing, Rebilling & Adjustments**

**August 1998**

## **About this publication**

**This publication supersedes all previous billing instructions for Healthy Options/  
Licensed Health Carrier Billing Instructions.**

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August 1998

**To request additional copies, make changes to your mailing address, or be removed from  
our mailing list, write to:**

Provider Inquiry & Relations  
PO Box 45562  
Olympia, WA 98504-5562

# Table of Contents

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<b>Important Contacts</b> .....	ii
<b>Definitions</b> .....	1
<b>Licensed Health Carrier Information</b> ....	4
Who should use these billing instructions?	
Billing Time Limits	
What are supplemental premiums and when are they necessary?	
Charts/Records	
Third-Party Resources	
<b>How do I bill for...?</b> .....	6
Capitated Premiums for Newborns .	
Supplemental Payments for Newborns Enrolled in Healthy Options	
Supplemental Payments for Clients (other than newborns) Enrolled in PCCM?	
FQHC/RHC Enhancement Payments	
Delivery Case Rate	
FQHC/RHC Delivery Case Rate Enhancement	
BHP Maternity “S” Supplemental	
FQHC/RHC BHP Maternity “S” Supplemental Enhancement	
<b>Supplemental Premium Procedure Codes</b> ....	12
Filling out the HCFA-1500 Claim Form.....	13
Samples: Completed HCFA-1500 Claim Forms	
<b>Rebilling and Adjustments</b> .....	16
<b>Filling out the Adjustment Request Form (525-109)</b> .....	18
Sample Adjustment Request Form (525-109)	
<b>Multiple Premium Payment Adjustments</b> ....	21
Sample Multiple Premium Payment Adjustment Form	
<b>Monthly Adjustment Report (Blank/Sample)</b> .....	A1-2

# Important Contacts

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## **WHERE DO I CALL TO APPLY FOR A PROVIDER #**

Call the Provider Enrollment Unit according to the first letter of your business name:

<b>A-H</b>	<b>(360) 664-0300</b>
<b>I-O</b>	<b>(360) 753-4712</b>
<b>P-Z</b>	<b>(360) 753-4711</b>

## **WHERE DO I SEND HARDCOPY CLAIMS?**

**Division of Program Support  
PO Box 9245  
Olympia WA 98507-9245**

## **WHERE DO I SEND MAGNETIC TAPES/FLOPPY DISKS?**

**Division of Program Support  
PO Box 45560  
Olympia, WA 98504-5560**

## **WHERE DO I CALL IF I HAVE QUESTIONS REGARDING...?**

Policy, payments, denials, general questions regarding claims processing or Healthy Options, or to request billing instructions?

**Provider Inquiry & Relations  
1-800-562-6188**

Contract issues?

Please contact the MAA Contract Manager for the carrier.

Private insurance or third-party liability, other than Healthy Options?

**Coordination of Benefits Section  
1-800-562-6136**

For information on *electronic billing* call:

**Electronic Billing Unit  
(360) 753-0318**

Additional information regarding MAA medical care programs, eligibility and limitations can be found in the MAA **General Information Booklet**.

# Definitions

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**Basic Health Plan (BHP)** - Health care services for qualified, low-income persons.

- **BHP “S”** – Health care services for BHP women who become pregnant
- **BHP+** - Health care services for children in BHP families who are enrolled in Healthy Options.

**Client** - An applicant for or recipient of DSHS medical care programs. (WAC 388-500-0005)

**Code of Federal Regulations (CFR)** - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

**Community Services Office (CSO)** - An office of the department which administers social and health services at the community level. (WAC 388-500-0005)

**Core Provider Agreement** - A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

**Department** - The state Department of Social and Health Services (DSHS).

**Dual Coverage** - When an MAA client is enrolled with the same Licensed Health Carriers both through Medicaid and another insurance contract (i.e., through employer of spouse, parent, or guardian).

**Explanation of Benefits (EOB)** - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

**Federally Qualified Health Center (FQHC)** - A facility that is: 1) receiving grants under section 329, 330, or 340 of the Public Health Services Act; OR 2) receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant, OR 3) a tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638). Only Health Care Financing Administration-designated FQHCs under a current contract with a *Healthy Options* contract health carrier will be allowed to participate in the program.

**Health Care Financing Administration (HCFA)** - A federal agency within the U.S. Department of Health and Human Services that oversees Medicaid and Medicare policies and procedures. HCFA also defines and assesses the quality of and the standards for health care delivery.

**Healthy Options** – Washington State’s Medicaid managed care program that

provides medical coverage for low-income women, children, and families.

**Licensed Health Carriers** - An organization that provides or arranges for medical services for enrolled clients in exchange for a prepaid premium. The term *Licensed Health Carrier* is used to identify Health Maintenance Organizations (HMOs), and Health Care Service Contractors (HCSCs) that are certified under state law to provide medical care on a risk basis and contracts with the Department.

**Licensed Health Carriers Service Area** - The geographic area defined by contract.

**Medicaid** - The federal aid Title XIX program under which medical care is provided to:

- Categorically needy as defined in WAC 388-503-0310 and 388-503-1105; or
- Medically needy as defined in WAC 388-503-0320. (WAC 388-500-0005)

**Medical Assistance Administration (MAA)** -The unit within the department of social and health services authorized to administer the Title XIX Medicaid and the state-funded medical care programs. (WAC 388-500-0005)

**Patient Identification Code (PIC)** - An alphanumeric code which is assigned to each Medicaid client and which consists of:

- a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- c) First five letters of the last name (and spaces if the name is fewer than five letters).
- d) Alpha or numeric character (tie breaker).

**Primary Care Case Manager (PCCM)** - A physician, Advanced Registered Nurse Practitioner, or Physician Assistant who provides, manages, and coordinates medical care for an enrollee. The PCCM is reimbursed fee-for-service for medical services provided to clients as well as a small monthly management fee.

**Primary Care Provider (PCP)** - A provider who provides, manages, and coordinates medical care for a licensed health carrier enrollee. The PCP generally is responsible for authorizing in advance, health care services performed by other providers. The only exceptions to this preauthorization requirement are a medical emergency, and/or services covered by MAA but not included under the contract with the licensed health carrier.

**Provider or Provider of Service** - An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department. (WAC 388-500-0005)

**Program Support, Division of (DPS)** - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

**Remittance And Status Report (RA)** - A report produced by the claims processing system in the Division of Provider Services, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

**Revised Code of Washington (RCW)** - Washington State laws.

**Rural Health Clinic (RHC)** - A certified clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases. Only Department of Health (DOH) certified RHCs under contract with a Healthy Option's health carrier will be allowed to participate in the program.

**Supplemental Premium** - A premium billed by the Licensed Health Carrier which has *not* been prepaid by the MAA premium payment system.

**Third Party** - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. (WAC 388-500-0005)

**Washington Administrative Code (WAC)**  
Codified rules of the State of Washington.

# Licensed Health Carriers

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## Who should use these instructions?

The Medical Assistance Administration's (MAA) premium payment system makes monthly payments in advance to Licensed Health Carriers for MAA clients enrolled as members. These billing instructions are to be used by:

- the carriers, when billing supplemental premium payments; and
- the Primary Care Case Management (PCCM) contractors for tribal, Indian Health Service, and urban Indian clinics who provide Healthy Options services to certain Native American clients.

## Billing Time Limits

You must submit your final billing to MAA within one (1) year from the end of the month in which the service was provided (e.g., a premium for September 1997 must be submitted by September 30, 1998).

**Note:** These instructions do not address how to bill for services covered by MAA which are not the contractual responsibility of the Licensed Health Carriers. Those non-contract services are billed on a fee-for-service basis using the billing instructions written for the specific type of service provided. (Call the Provider Inquiry Unit at 1-800-562-6188 to request copies of other available billing instructions.)

## Supplemental Premiums

### What are they? When are they necessary?

Supplemental premiums are premiums which have not been prepaid by the premium payment system but are authorized by the Healthy Options contract. Supplemental premium payments must be billed on the HCFA-1500 claim form.

Supplemental premiums are necessary when:

- the carrier identifies a baby born to a woman who is enrolled with the carrier at the time of delivery;
- an enrolled, pregnant client delivers (delivery case rate); or
- a Basic Health Plan (BHP) member, who is eligible for the Medicaid "S" program, delivers.

## Charts/Records

You must maintain legible, accurate, and complete charts/records to support/justify the services for which you are reimbursed. These charts/records must be made available to MAA or its agents upon request.

## Third Party Resources

You must maintain records substantiating that all third-party resources (TPR) available to MAA clients have been identified and pursued. You must report all information which is not listed on the TPR quarterly report to MAA's TPR program:

**Coordination of Benefits  
Division of Client Support  
PO Box 45561  
Olympia WA 98504-5561  
- or call -  
1-800-562-6136**

# How do I bill for...?

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## Capitated premiums and/or supplemental payments for newborns enrolled in Healthy Options

Medical coverage through licensed health carriers for babies born to an enrolled parent(s) is effective on the date of birth. However, premium payments for newborn babies cannot be automatically generated by the MAA payment system.

- Carriers will be paid a full month's premium regardless of the newborn's date of birth during the month.
- Bill for supplemental premiums using the assigned newborn **procedure code 0351M**.  
Bill for supplemental PCCM payments using the assigned newborn **procedure code 0353M**.
- Enter the newborn's patient identification code (PIC) in field 1a, and enter the baby's name and birthdate in fields 2 and 3 on the HCFA-1500 claim form.
- MAA will pay **newborn supplemental** premiums billed up to the end of the month in which the sixtieth (60th) day after the birth occurs – unless the baby has been enrolled during this period.

<b>Example:</b> 1	If a baby is born on July 15, 1998, and enrollment is not completed by September 30, 1998, coverage will end on September 30, 1998.
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- A maximum of three months' supplemental premiums will be paid for newborns who have not otherwise been enrolled.
- The baby's parent(s) must inform the local Community Services Office (CSO) of the baby's birth in order for the child to receive a PIC.

## EXCEPTIONS

There may be situations where it is difficult to obtain the baby's PIC. In these situations, you may use a parent's PIC to bill newborn supplemental premiums. You may bill newborn supplemental premiums up to the end of the month in which the 60<sup>th</sup> day after birth occurs, if appropriate.

If billing hard copy, indicate one of the following statements in field 19\* under "Reserved for local use" on the HCFA-1500 claim form:

- Baby on Parent's PIC – Family left state before baby had PIC;
- Baby on Parent's PIC – Baby adopted mo/yr before baby had PIC;
- Baby on Parent's PIC – Baby died mo/yr before baby had PIC; or
- Baby on Parent's PIC – Baby's DOB>6 mo. & not in Medicaid.

If billing electronically, indicate one of the above statements in the appropriate field as follows:

- Electronic Media Claim – In field 19, "Remarks";
- Tape Format – In Detail Medical record, field 20, "Remarks"; or
- Multi-Insurer – In D2 record, field 7, "Remarks."

Bill premiums only for months when both mother and baby were eligible. For example, if a baby is born and adopted in January, MAA will allow no February premiums.

## Supplemental Payments for Clients (other than newborns) who are enrolled in PCCM

When billing supplemental payments for clients (other than newborns) enrolled in PCCM, use **procedure code 0352M** on the HCFA-1500 claim form. (See instructions for HCFA-1500 field 24D.) Billings under this procedure code occur very rarely and should be coordinated with the carrier's contract manager at MAA.

\* Message in "field 19" cannot exceed 40 characters.

## Federally-Qualified Health Center (FQHC)/ Rural Health Center (RHC) Enhancement Payments

MAA will send FQHC/RHC enhanced payments directly to the FQHC/RHC for enrolled Healthy Options and Basic Health Plan Plus clients. Carriers will continue to receive the capitated managed care premium.

Carriers must submit a monthly adjustment report to MAA for FQHC/RHC enrollees who were not indicated, or were incorrectly indicated as enrolled with the FQHC/RHC, on the monthly payment tape. The monthly adjustment report must reach MAA no later than the 15th of each month in order for changes to be effective the following month. See page A-1 for a sample report.

The monthly adjustment report may indicate three conditions:

- **A client is no longer enrolled with the FQHC/RHC indicated.**  
MAA will remove the FQHC/RHC indicator for the following month.  
The client will remain enrolled with the carrier.
- **A client is enrolled with a different FQHC/RHC than was indicated.**  
The carrier should indicate the correct FQHC/RHC and MAA will make the change for the following month.
- **A client is enrolled with an FQHC/RHC, but the payment tape did not indicate FQHC/RHC enrollment.** The carrier should indicate which FQHC/RHC the client is enrolled in and the effective date of the FQHC/RHC enrollment. MAA will enroll the client in the FQHC/RHC indicated and make retroactive enhanced payments for up to three months.



**NOTE:** This monthly report cannot be used to enroll a client with the carrier. It is only used for enrollment with an FQHC/RHC.

**Example:** The carrier notices that the June payment listing indicates that a client, who has been with an FQHC since March, is enrolled just with the carrier. A check of previous month's listing shows MAA has never had the client enrolled with the FQHC. On the monthly adjustment report, the carrier should indicate enrollment with the appropriate FQHC effective April 1 and continuing. MAA will process the adjustment report and make retroactive enhancement payments for April, May, and June (maximum retro-payment of three months) directly to the FQHC.

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Enhancement payments will be reflected on the FQHC/RHCs' remittance and status report **as procedure code 0357M**. Carriers may use the HCFA-1500 claims form to bill MAA for enhancement payments if the client is not on the adjustment report.

**Example:** When a client is enrolled in an FQHC/RHC, the carrier may submit a HCFA-1500 claim form for enhanced payment if the client is not on the adjustment report.

**HCFA-1500 Claim Form using:**

- ✓ Procedure code 0357M (FQHC/RHC Enhancement);
- ✓ Carrier Provider Number next to GRP# in field 33; and
- ✓ FQHC/RHC Provider Number next to PIN# in field 33.

## Delivery Case Rate

MAA has removed costs associated with deliveries from the monthly capitated premium rate. Carriers may bill a delivery case rate using **procedure code 0365M**, only if the carrier has the client enrolled at the time of delivery. Abortion, either spontaneous or induced, is not considered a delivery. If there are multiple births, only one delivery case rate will be paid. However, MAA will pay multiple premium newborn supplemental premiums for *each* of the babies.

## FQHC/RHC Delivery Case Rate Enhancement

If the client is enrolled with an FQHC/RHC at the time of delivery, the carrier must submit a separate HCFA-1500 claim form using **procedure code 0366M**. The appropriate FQHC/RHC provider number (beginning with 759) must be indicated in field 33 (GRP#) and the carrier provider number (beginning with 750) must be indicated in field 26 (Patient's Account No.). The enhancement amount will be paid directly to the FQHC/RHC.

**Example:** When an FQHC/RHC enrolled client delivers, the carrier should submit two (2) HCFA-1500 claim forms.

**HCFA-1500 Claim Form #1 using:**

- ✓ Procedure code 0365M (Delivery Case Rate); and
- ✓ FQHC/RHC Provider Number next to P.I.N.# in field 33; and
- ✓ Carrier Provider Number next to GRP# in field 33.

**HCFA-1500 Claim Form #2 using:**

- ✓ Procedure code 0366M (FQHC/RHC Delivery Care Rate Enhancement); and
- ✓ **Carrier Provider Number in field 26 (Patient's Account No.); and**
- ✓ FQHC/RHC Provider Number next to GRP# in field 33.

## BHP Maternity "S" Supplemental

BHP members who become pregnant may remain with their BHP carrier and MAA will generate monthly capitated premiums to BHP for them. After delivery, the BHP carrier may bill MAA for prenatal and delivery costs using **procedure code 0367M** on the HCFA-1500 claim form, only if the carrier has the client enrolled at the time of delivery. Abortion, either spontaneous or induced, is not considered delivery.

**Example:** When a BHP "S" client delivers, the carrier should bill  
2 procedure codes 0365M and 0367M.

## Federally Qualified Health Centers (FQHC)/Rural Health Centers (RHC) BHP Maternity "S" Supplemental Enhancement

If the BHP “S” client is enrolled in an FQHC/RHC, the carrier must submit a separate HCFA-1500 claim form using **procedure code 0368M**. Be sure the appropriate FQHC/RHC provider number (beginning with 759) is indicated in field 33 (GRP#) and the carrier provider number (beginning with 750) is indicated in field 26 (Patient’s Account No.). The enhancement amount will be paid to the FQHC/RHC.

**Example:** When a BHP “S” client who is enrolled in an FQHC/RHC delivers, the carrier should submit two (2) HCFA-1500 claim forms.

### HCFA-1500 Claim Form #1 using:

- ✓ Procedure codes 0365M (Delivery Case Rate) and 0367M (BHP Maternity “S” Supplemental); with
- ✓ Carrier Provider Number next to GRP# in field 33; and
- ✓ FQHC/RHC Provider Number next to P.I.N.# in field 33.

### HCFA-1500 Claim Form #2 using:

- ✓ Procedure codes 0366M (FQHC/RHC Delivery Case Rate Enhancement and 0368M (FQHC/RHC BHP Maternity “S” Supplemental Enhancement); with
- ✓ **Carrier Provider Number in field 26 (Patient’s Account No.); and**
- ✓ FQHC/RHC Provider Number next to GRP# in field 33.

# Supplemental Premium Procedure Codes

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To bill MAA for supplemental premiums, use the state-assigned procedure codes listed below.  
(See HCFA-1500 claim form instructions, field 24D.)

0350M	Monthly Capitated Premium for All Clients Other Than Newborns.
0351M	Monthly Capitated Premium for Newborns.
0352M	PCCM Monthly Payment for All Clients Other Than Newborns.
0353M	PCCM Monthly Payment for Newborns.
0357M	FQHC/RHC Enhancement
0365M	Delivery Case Rate.
0366M	FQHC/RHC Delivery Case Rate Enhancement.
0367M	BHP Maternity "S" Supplemental.
0368M	FQHC/RHC BHP Maternity "S" Supplemental Enhancement.

# Filling out the HCFA-1500 Claim Form

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The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

## General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
  - Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
  - All information must be centered within the space allowed.
  - Use upper case (capital letters) for all alpha characters.
  - Do not write, print, or staple any attachments in the bar area at the top of the form.
- 

1a. **Insured's I.D. No.:** Enter the Medicaid Patient Identification Code (PIC), an alphanumeric code assigned to each Medical Assistance client. This information is obtained from the client's current monthly medical ID card, and consists of the client's:

- First and middle initials (or a dash (-) if the middle initial is not indicated)
- Six-digit birthdate, consisting of *numerals only* (MMDDYY)
- First five letters of the last name
- An alpha or numeric character (tie breaker)

**The medical assistance ID (MAID) card is your proof of eligibility for medical assistance.** Use the PIC code of either parent if a newborn has not been issued a PIC and enter one of the appropriate reasons in field 19 (see field 19 instructions).

2. **Patient's Name:** Enter the last name, first name, and middle initial of the Medicaid client.

3. **Patient's Birthdate:** Completion of this field is recommended. List the birthdate of the Medicaid client. If newborn, use date of birth.

19. **Reserved For Local Use:** If a newborn has not been issued a PIC, use the PIC code of either parent (in field 1a) and enter one of the following statements (whichever applies):
- Baby on Parent's PIC – Family Moved
  - Baby on Parent's PIC – Adopted or Foster Care
  - Baby on Parent's PIC – Mother or Baby Deceased
  - Baby on Parent's PIC – Mother Disenrolled
- 24A. **Date(s) of Service:** Enter numerically the to and from month, day, and year of service (e.g., August 01, 1998 to August 31, 1998 = 080198 - 083198). If newborn, use the date of birth through the end of month. Do not use dashes (-) or slashes (/).
- 24B. **Place of Service:** Enter a 3 for place of service.
- 24C. **Type of Service:** Enter a 3 for all services billed.
- 24D. **Procedures, Services or Supplies CPT/HCPCS:** Enter only the appropriate procedure code from *page 9* of these billing instructions.
- 24E. **Diagnosis Code:** Enter diagnosis code **V99.0**.
- 24F. **\$ Charges:** Enter the appropriate supplemental premium payment amount under your contract. Do not use dollar signs (\$) or decimals (.).
- 24G. **Days Or Units:** Enter the number *1* to indicate one unit for each line.
26. **Patient's Account No./**

**Carrier Provider Number**

A. Patient Account No: (**Not Required**) This is a alphanumeric entry up to 13-digits that you may use as your internal reference number. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column headed "Medical Record Number." (Note: you might consider using this number to separate various accounts associated with your office, such as the accounts in different branch offices.)

B. Carrier Provider No.: (**Required for FQHC/RHC Enhancement claims only**) Enter the 7-digit carrier provider number (beginning with 750xxxx) directly after your internal reference number (as listed above) if entered.

For electronic claims, your internal reference number cannot be used. This field cannot exceed 9 digits for electronic claims processing. If you choose to include your internal reference number in this field, you must submit hard copy claims.

28. **Total Charge:** Enter the sum of your charges. Do not use dollar signs (\$) or decimals (.).
30. **Balance Due:** Enter total charges. Do not use dollar signs (\$) or decimals (.).
33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #:** Enter the name, address, and telephone number of the service provider, as recorded with MAA.

**P.I.N.:** If applicable, enter the performing provider number of the FQHC/RHC the client is enrolled with.

**Group: (Required for FQHC/RHC Enhancement claims)**

Enter the 7 digit "Pay To" provider number of the FQHC/RHC (beginning with 759XXXX) assigned to you by the Division of Program Support when you signed your Core Provider Agreement (unless instructions specify otherwise). This is the seven-digit provider number that appears on the Remittance and Status Report received with reimbursement for services. Please use this number on all forms and inquiries.

# Rebilling and Adjustments

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Rebilling and adjustments are used to correct billing errors. Knowing when to use the rebilling process versus the adjustment process is important and will ensure correct payments.

The following information will help to clarify the difference between rebilling and adjustments.

- A. REBILLING:** When rebilling beyond the 365-day billing time limit, reference the Internal Control Number (ICN) for the denied claim. Or attach the Remittance and Status Report verifying the claim was originally submitted within the time limit.  
(*Note:* If rebilling electronically, indicate the original ICN in the *Remarks/Comments* field.)

Use the **rebilling process** when:

- **The claim is denied in full.** When the entire claim is denied, make any necessary corrections and resubmit your claim.
- **An individual line is denied on a multiple-line claim.** The denied service may only be submitted as a rebill.
- **The claim does not appear on the Remittance and Status Report.** If at least ninety days have elapsed since you sent your claim to MAA *and* it has not appeared on the Remittance and Status Report, resubmit the claim.

**Remember:** Present your final bill to MAA for reimbursement no later than 365 days from the date of service [RCW 74.09.160].

- B. ADJUSTMENTS:** Rebillings are not appropriate for the following situations and you must submit an adjustment when:

- **The claim has been underpaid.** Line items or claims paid at an amount less than the contract premium amount should be resubmitted as an adjustment.
- **The claim has been paid and an error was made** in procedure codes or anything else that may affect payment.
- **The client is covered under the same licensed health carrier by another third-party** (dual coverage).

(See the Multiple Premium Payment Adjustments section for third-party liability.)

- **The claim was overpaid.** If you discover an overpayment, you may either:
  - ⇒ **Submit an adjustment.** MAA will recoup the claim and deduct the excess amount from future remittance check(s) until the overpayment is satisfied; **OR**
  - ⇒ **Issue a refund check payable to DSHS.** Attach a copy of the Remittance and Status Report showing the paid claim and include a brief explanation for the refund (i.e., insurance payment, duplicate payment). Mail the above items to:

**Office of Financial Recovery (MED)**  
**PO Box 9501**  
**Olympia WA 98507-9501**

- ◆ Single adjustments must be submitted on the Adjustment Request Form 525-109.
- ◆ Multiple premium adjustments must be submitted on the Multiple Premium Payment Adjustments Form.

**Adjustments are processed through these steps:**

1. The Medicaid Management Information System (MMIS) locates the claim to be adjusted. The message CRE (CREDIT) appears in the EOB column on the MAA Remittance and Status Report.
2. The action requested is completed and the claim is processed accordingly.

Requesting an adjustment does not necessarily mean the claim will be paid. The adjusted claim may again be denied if the original disposition was correct or if the information provided on the Adjustment Request is incorrect.

Documentation must be attached to the adjustment request (Remittance and Status Reports, eligibility verification, etc.) to avoid redetermination or incorrect disposition of the claim.

# Filling out the Adjustment Request Form (525-109)

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Use the Adjustment Request form 525-109 (Rev. 11/91) for *single correction* requests. The numbered blocks on the form are referred to as *fields*. Complete the fields as explained below, recording the requested information off of your Remittance and Status Report exactly as it appears there. For multiple corrections concerning one client, use the Multiple Premium Payment Adjustment form.

<b>Field 1</b>	<b><u>Type of Claim</u></b>  Check the type of claim <i>originally submitted</i> for payment.	<b>Field 5*</b>	<b><u>Date(s) of Services</u></b>  Enter beginning and ending dates of service for the entire claim, not just the line item to be adjusted.
<b>Field 2*</b>	<b><u>Claim Number to be Adjusted</u></b>  Enter the 17-digit ICN number of the claim to be corrected. Submit only one adjustment request per ICN number.	<b>Field 6</b>	<b><u>Patient's Name</u></b>  Enter the client's last name, first name, and middle initial.
<b>Field 3*</b>	<b><u>Provider Number</u></b>  Enter your MAA assigned provider number as shown on the Remittance and Status Report.	<b>Field 7*</b>	<b><u>R.R. Date</u></b>  Enter the date of the Remittance and Status Report (shown in the upper right corner of the report).
<b>Field 4*</b>	<b><u>Patient ID from Remittance Report</u></b>  Enter the client's PIC as shown on the medical ID card.		<b><u>EOB(s) on R.R.</u></b>  Enter the <i>EOB code</i> on the Remittance and Status Report that explains the reason for denial, cutback, etc. <i>Note:</i> If there is no code, leave blank.

\* This field must be completed or the adjustment request will be denied.

**Field 8      Date of Request**

Enter today's date.

**Field 9      Corrected Patient ID**

Use this area if a service has been paid under a wrong ID code *or* if a service was previously billed for a baby under a parent's PIC and the baby now has his/her own PIC.

If a claim has been denied with **EOB 011 or EOB 015**, use the ***rebilling procedure***, correcting the PIC or attaching a copy of the medical assistance ID card to the claim to verify the client's eligibility for date of service.

**Field 10**

<b><u>Items to be</u></b>	<b><u>Information</u></b>	<b><u>Corrected</u></b>
<b><u>Corrected</u></b>	<b><u>on R.R./Claim</u></b>	<b><u>Information</u></b>

Locate the item(s) <i>to be corrected.</i>	Enter <i>incorrect</i> information as it appears on the Remittance and Status Report or on the original claim.	Enter the <i>corrected</i> data.
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NOTE: Fill in only the areas needing correction(s).

**Field 11      Other Remarks/Justification/  
Award Letters/Approvals**

This space is for information on the adjustment.

**Field 13      For DSHS Use**

**Field 14      Provider Name and Address**

Enter your phone number.  
Enter your name and address as shown on the Remittance and Status Report.



# Multiple Premium Payment Adjustments

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The Multiple Premium Payment Adjustment found on the following page is intended for use by carriers when several months of premium payments are being adjusted for the same client. This may occur when:

- The client chooses to no longer participate with the licensed health carrier, or
- A third party is involved, creating *dual coverage*. (See definition of dual coverage on page 1.)

**This form may be used to adjust up to six claims for the same client.**

## **Instructions for Completing the Premium Payment Adjustment Form:**

- Enter in the top portion of the form:
  - ☐ The date.
  - ☐ The provider's name and address.
  - ☐ The provider number assigned by MAA.
  - ☐ The provider's phone number.
  - ☐ The client's PIC code (from his/her medical assistance ID card).
  - ☐ The client's name.
- Enter in each box (**use a separate box for each claim**):
  - ☐ The claim number to be adjusted.
  - ☐ The dates of service (from and to).
  - ☐ The amount to be adjusted for each claim.
- Indicate the reason for the adjustment at the bottom of the form.

These adjustments will appear on the MAA Remittance and Status Report. Using this method of making adjustments will provide the carrier with a record showing that these overpayments have been recouped.

If the FQHC or RHC has received an enhancement, then these payments will also be recouped.

